NATIONAL HEALTH PLANNING: STRUCTURE AND GOALS*

HOLLIS S. INGRAHAM, M.D.

Commissioner
New York State Department of Health
Albany, N.Y.

ANY panel that proposes to consider national health planning has its work cut out for it. Much as we have needed such planning, there has not been much of it in the past. Nor have we had a coherent national health policy. In fact, it was not until several years ago that the U. S. Department of Health, Education, and Welfare (HEW) acknowledged that the federal government had no health policy. What health policy we had was determined by the president, Congress, and federal agencies—acting alone or in combination.

Our elected leaders, of course, will always be the final arbiters of national health programs. The problem is: How good is the advice they receive, and with what alternatives are they confronted?

Presidents and members of Congress come and go. One cannot look to the federal health bureaucracy, as it is presently constituted, for continuity and consistency. The last time someone looked, there were 23 federal agencies with health responsibilities. Often these agencies work at cross purposes or duplicate one another's efforts. Nor is there a single person in charge of health planning, policy making, and administration. Dr. Roger O. Egeberg, assistant secretary for Health and Scientific Affairs in HEW, is commonly believed to be the nation's top health administrator, but he has direct administrative control over only about 17% of the money that the federal government spends for health purposes.

Two years ago a member of the staff of a Senate subcommittee looked into this situation. He reported that some federal agencies did not even know the number of health programs they had. One agency did not even know that it had any. It did—a program budgeted at

* Presented in a panel, National Planning for Health: Structure and Goals, as part of the 1971 Health Conference of the New York Academy of Medicine, *Toward a National Health Program,* held at the Academy April 29 and 30, 1971.

$50 million. This chaotic situation is the fault of no one in particular. It is just something that has grown up like an untended garden. It was not always such a jumble, or at least so visible a jumble.

At one time the Public Health Service and Commissioned Corps provided a garrison corps of career physician administrators and specialists in health areas. However, events have conspired to downgrade the Public Health Service.

One of those events was the passage of Medicare-Medicaid. This landmark legislation put the federal government squarely into the business of financing medical care for many additional millions of Americans. Today the federal government pays half the hospital bills of the nation. And the Medicare-Medicaid program has brought boiling to the surface all the festering problems that have to do with the financing, availability, and quality of health care that the nation did not know it had before.

This legislation was debated, in one form or another, for more than a decade, then passed in a fit of haste. Only recently have its shortcomings become so painfully evident to the American people: its inflationary impact on health care, the shortsighted cost-plus reimbursement that it mandates, the shortages in medical manpower that it has aggravated, and the unevenness in quality and availability of care.

I think it is fair to ask: Would Medicare-Medicaid, with all its obvious shortcomings, have passed in its present form if we had a good mechanism for developing a national health policy six years ago? I suspect that it would not.

Medicare-Medicaid was basically sound social legislation. Our political leaders had a good idea, but received bad technical advice for implementing it. It was not a failure of political vision. It was a failure of administrative and professional acumen.

There is a lesson there that ought to guide our present attempts to construct a workable mechanism for developing national health planning and policy. In this nation we have the administrative and professional expertise to give sound advice to our political leaders. Some of it is present at this conference. The trick is to position that expertise so that it can make useful and timely contributions to framing national health policy and federal health legislation. That is a vital need. Because every time a good social program fails in any way through poor administrative implementation we lose public trust, and that is absolutely

essential to good government. We can never afford an erosion of public trust, especially in the present climate of social unrest.

A first order of business is a complete overhaul of the federal machinery for the development of health policy: a task which has been occupying the attention of men such as Karl D. Yordy, to whom we wish every success. I hope Mr. Yordy agrees with me that one of our most basic needs is to put someone in charge of health administration—not 17% of it, but most of it.

Not only do we need a single national health administrator to provide accountability: we also need a single, national health agency, a Department of Health, to provide cohesiveness in federal health programming—an agency that would place under a single organizational roof most of the health programs now scattered around the federal establishment. Notice that I say most—health is too broad a concern to be totally encompassed in a single agency.

Our third basic need is to staff this federal department of health with a corps of dedicated career professionals—well-paid and highly motivated by a career system that rewards ability wherever it is found. Appointing administrators who have had no previous background in government is a losing proposition. Occasionally such officials stay long enough to learn the job and then depart—often leaving problems in their wake for the next neophyte to grapple with before he too is able to learn the ways of government. That is the wrong way to operate.

The right way is to maintain a career service, staffed by health administrators who are professionally competent, politically sensitive, wise in the ways of government, and closely in tune with the problems of states and localities. These are the fundamental ingredients for developing a sound and cohesive national health policy.

It can be fairly argued whether the purging in this decade of the Public Health Service and its Commissioned Corps was an inevitable consequence of the government's shifting focus from traditional public health activity to the financing and delivery of health care. What cannot be argued is that the need for such a career organization persists—and that it is intensified by the critical problems the nation faces in devising a more effective health care delivery system.

I hope too that federal health reorganization will be accompanied by a better method for distributing federal aid to the states. Categorical aid grants that allocate money to the states by specific disease and

health-problem categories have had their success, but in the long run they are unsatisfactory. The health problems of Alabama are not the health problems of New York State. The incidence of a disease varies among the states. Social and ethnic factors vary.

Another form of federal aid that suffers from serious shortcomings is the project grant. The lion's share of project-grant money goes to the big, powerful agencies that have the staff know-how to compete for available funds in this category, while the small health agencies that often have the greatest real needs are left out in the cold, simply because they have no one on their staffs who understands the subtle arts of grantsmanship. So the end result is that "them what has, gets"—which is probably all for the best where research projects are concerned, since larger institutions are better suited for such work—but decidedly unfair in federal funding for direct program services. Block grants are fine in theory, but in practice they seem to die from inflationary pressures and lack of political appeal.

A third criticism of federal aid is that it too often bypasses the official state health agency, which happens to be the one organization best suited to evaluate where the most urgent need exists. This bypassing of the states directly violates a constitutional inference that health care is the primary responsibility of the states. Yet the federal government has been able to arrogate to itself the health functions of government because it has had the superior revenue-raising power to do so. I do not say that health care should be totally decentralized. That would be neither practical nor desirable. But some return to the principles of Jeffersonian democracy is called for when the federal government gives back to a state like New York only 11 cents of every dollar we send to Washington, then tells us exactly how we may spend the 11 cents. We need a federal aid plan that puts the money where the problems are—as Governor Nelson A. Rockefeller's revenue-sharing proposal would do.

On the issue of national health planning I confess to a mixture of feelings. Comprehensive national health planning is noble in concept. The health field has suffered too long from a lack of planning at all levels. That is why I remain an advocate of the Federal Partnership for Health Planning Act.

New York State and its communities have seized eagerly upon this law, and our comprehensive planning is well under way. We have a

State Health Planning Commission, of which I am chairman—and we are at work on a state health plan.

We also have seven areawide health-planning agencies, five of which are funded for their operational phase already. National health planning must be designed to complement these state and area planning bodies, not to supplant them. My principal criticism of the Federal Partnership for Health Planning is that too much was expected of too many too soon. Great pronouncements and predictions were not followed by the level of federal appropriations needed to carry out the plans. False hopes were raised—only to be dampened by a trickle of federal aid and a stream of federal directives. Remote control from Washington is not planning. It is a thinly disguised puppet show that will not work. Far less time must be spent issuing regulations from Washington, and more time devoted to putting the federal house in order.

Obviously if the method of planning called for in the Partnership for Health Planning legislation is good for the localities and the states, a similar mechanism should work at the central level. When the federal health establishment is sprawled over 23 federal agencies, then it is a pure and simple case of "physician, heal thyself." Our federal brethren urgently need to organize a coherent structure: by giving central responsibility for coordinating national health policy to one person, by establishing a federal Department of Health that will enable our national government to speak with one voice instead of 23 when it deals with the states and localities, and by manning this central structure with a highly motivated cadre of career physicians.

Once this structure is established, a National Council of Health Advisers would then prove a useful adjunct. Such a council should not be a consortium of special-interest groups. It should be made up of men and women with impeccable reputations owing allegiance only to the public interest—and representing the best thought that can be brought to bear on the problems of health care.

But I stress this: a Council of Health Advisers is a need that is secondary to the need for a career corps of health administrators, not all of whom need be physicians, who understand both the requirements of health and the workings of government, who have a working sensitivity to the problems of states and cities, and who are highly motivated by a soundly structured career system.

C. P. Snow has pointed out that rational decisions cannot be made today by government without a very strong input from the scientific and technological fields. This is especially true in the field of health. The science and technology of health care is growing rapidly. Scientists are at work now seeking ways to discover the final mysteries of life itself. Some day human life may be reproducible in a laboratory setting. This will evoke a ponderous dilemma, both in scientific terms and in human terms. Similar agonizing dilemmas are already upon us. Thousands of dollars can be spent now on a heart-transplant procedure that will sustain a single human life for a year or so. Is that money better spent preventing a score or more of infants from falling victims to a crippling lifetime disease? I do not pretend to know the answer to that question. My point is that such problems are both scientific and human—and that they will continue to confront us.

To resolve them with any satisfaction at all will require a good working relation between those who represent the public view and those who possess the scientific and technological know-how. Both have something profoundly important to contribute to the process of making the decisions that will be thrust upon us. We need to create a workable structure to ensure that both will be fairly heard, not after the legislation has been passed and the regulations written, but when the legislation is being debated and considered. And that brings me to my final point.

Planning today is being conducted at all levels in an atmosphere in which the skills and motives of the professionals are regarded as suspect. At the same time the consumer is being placed on a pedestal. Time and experience will probably lead us to a better view. However, there is a real danger that many persons now enthusiastically engaged in the planning process will be discouraged when well-laid plans are not promptly implemented.

In our society the final planners are the elected representatives. It is they who must raise the money, make the important cost-benefit ratio estimates—and get reelected. Other planners, both professionals and consumers, can at best give sage counsel. As power shifts increasingly to the central government, the need for such planning and counsel to our federal establishment becomes our first priority in public health.